Draft Language:

Section 12693.55 of the Insurance Code is amended to read:

12693.55. (a) A health care provider who is furnished documentation of a person's enrollment in the program shall not seek reimbursement nor attempt to obtain payment for any covered services provided to that person other than from the participating health plan covering that person or from other entities with which the board enters into contracts or interagency agreements to provide or pay for benefits under this part pursuant to Section 12693.26.

(b) The provisions of subdivision (a) do not apply to any copayments required under this part for the covered services provided to the person ~~under his or her participating health plan~~.

(c) For purposes of this section, "health care provider" means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

Section 12695.04 of the Insurance Code is repealed.

Section 12696.05 of the Insurance Code is amended to read:

12696.05. The board may do all of the following:

(a) Determine eligibility criteria for the program. These criteria shall include the requirements set forth in Section 12698.

(b) Determine the eligibility of applicants.

(c) Determine when subscribers are covered and the extent and scope of coverage.

(d) Determine subscriber contribution amounts schedules.

(1) Subscriber contribution amounts for care provided to the subscriber shall be indexed to the federal poverty level and shall not exceed 2 percent of a subscriber's annual gross family income.

(2) In addition to any other subscriber contribution specified in this subdivision, for subscribers enrolled on or after July 1, 2007, the board may also assess an additional subscriber contribution to cover the AIM-linked infant enrolled in the Healthy Families Program pursuant to clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70 for two months, using all applicable discounts pursuant to Section 12693.43.

(3) The board shall determine the manner in which the subscriber contributions are to be applied, including the order in which they are applied.

(e) Provide coverage through participating health plans or through coordination with other state programs, including, but not limited to, through interagency agreements with the State Department of Health Care Services to provide or pay for benefits to subscribers under this part, and contract for the processing of applications and the enrollment of subscribers. Any contract entered into pursuant to this part shall be exempt from any provision of law relating to competitive bidding, and shall be exempt from the review or approval of any

division of the Department of General Services. The board shall not be required to specify the amounts encumbered for each contract, but may allocate funds to each contract based on projected and actual subscriber enrollments in a total amount not to exceed the amount appropriated for the program.

(f) Authorize expenditures from the fund to pay program expenses which exceed subscriber contributions, and to administer the program as necessary.

(g) Develop a promotional component of the program to make Californians aware of the program and the opportunity that it presents.

(h) Issue rules and regulations as necessary to administer the program.

(1) All rules and regulations issued pursuant to this subdivision that manage program integrity, revise the benefit package, or reduce the eligibility criteria below 300 percent of the federal poverty level may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The adoption of these regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, and safety, or general welfare. The regulations shall become effective immediately upon filing with the Secretary of State.

(2) During the 2011-12, 2012-13, and 2013-14 fiscal years, the adoption and readoption of regulations pursuant to this part shall be deemed to be an emergency that calls for immediate action to avoid serious harm to the public peace, health, safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the board is hereby exempted from the requirement that the board describe facts showing the need for immediate action and from review by the Office of Administrative Law.

(i) Exercise all powers reasonably necessary to carry out the powers and responsibilities expressly granted or imposed by this part.

Section 12696.5 of the Insurance Code is repealed.

Section 12697.10 of the Insurance Code is amended to read:

12697.10. ~~(a)~~ The board shall include, within contracts negotiated pursuant to this part, terms regarding the cancellation of the contracts, and may cancel any contract negotiated pursuant to this part with any participating health plan as provided for in the contract.

~~(b) The board shall provide for the transfer of coverage of any subscriber to another participating health plan if a contract with any participating health plan under which the subscriber receives coverage is canceled or not renewed.~~

Section 12698 of the Insurance Code is amended to read:

12698. To be eligible to participate in the program, a person shall meet all of the following requirements:

(a) Be a resident of the state ~~for at least six continuous months prior to application~~. A person who is a member of a federally-recognized California Indian tribe is a resident of the state for these purposes.

(b) (1) Until the first day of the second month following the effective date of the amendment made to this subdivision in 1994, have a household income that does not exceed 250 percent of the official federal poverty level unless the board determines that the program funds are adequate to serve households above that level.

(2) Upon the first day of the second month following the effective date of the amendment made to this subdivision in 1994, have a household income that is above 200 percent of the official federal poverty level but does not exceed 250 percent of the official federal poverty level unless the board determines that the program funds are adequate to serve households above the 250 percent of the official federal poverty level.

(c) Pay an initial subscriber contribution of not more than fifty dollars ($50), and agree to the payment of the complete subscriber contribution. A federally recognized California Indian tribal government may make the initial and complete subscriber contributions on behalf of a member of the tribe only if a contribution on behalf of members of federally recognized California Indian tribes does not limit or preclude federal financial participation under Title XXI of the Social Security Act. If a federally recognized California Indian tribal government makes a contribution on behalf of a member of the tribe, the tribal government shall ensure that the subscriber is made aware of all the health plan options available in the county where the member resides.

Section 12698.26 of the Insurance Code is amended to read:

12698.26. (a) A health care provider who is furnished documentation of a subscriber's enrollment in the program shall not seek reimbursement nor attempt to obtain payment for any covered services provided to that subscriber other than from the participating health plan covering the subscriber or from other entities with which the board enters into contracts or interagency agreements to provide or pay for benefits under this part pursuant to subdivision (e) of Section 12696.05.

(b) The provisions of subdivision (a) do not apply to any copayments required under this part for the covered services provided to the subscriber ~~under his or her participating health plan~~.

(c) For purposes of this section, "health care provider" means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

Section 14011.78 is added to the Welfare and Institutions Code to read:

14011.78. (a) The department may contract with public or private entities, or utilize existing health care service provider payment mechanisms, including the Medi-Cal program's fiscal intermediary, in order to implement subdivision (b) of

Section 12693.26 and subdivision (e) of Section 12696.05 of the Insurance Code, only if services provided under those sections are specifically identified and reimbursed in a manner that appropriately claims federal financial reimbursement.

(b) Contracts under this section, including the Medi-Cal fiscal intermediary contract, and including any contract amendment, any system change pursuant to a change order, and any project or systems development notice, shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Section 19130 of the Government Code, and any policies, procedures, or regulations authorized by these laws.

Section 14017.7 of the Welfare and Institutions Code is amended to read:

14017.7 (a) In addition to the issuance of Medi-Cal cards, pursuant to Section 14017.8, the department may issue a benefits identification card for the purpose of identifying an individual who has been determined eligible for health care benefits under this chapter or health care benefits under another health care program administered by the department, or both.

(b) The department may also issue a benefits identification card for the purpose of identifying an individual who has been determined eligible to receive health care services from a Medi-Cal provider under one of the following programs.

(1) The Healthy Families Program under Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code.

(2) The Access for Infants and Mothers Program under Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code.

~~(b)~~

(c) In no event shall a benefits identification card be issued to an individual described in subdivision (a) or (b) unless appropriate and adequate safeguards have been implemented to ensure all of the following:

(1) If the individual has been determined eligible for health care benefits under another health care program administered by the department or a program identified in subdivision (b), that health care program pays for any and all health care benefits delivered to the individual by that health care program.

(2) State funds appropriated to or federal medicaid financial participation claimed by the Medi-Cal program shall only be used for the delivery of health care benefits authorized pursuant to this chapter.

~~(c)~~

(d) The individual described in subdivision (a) or (b) may present the benefits identification card to obtain health care benefits for which that individual has been determined eligible under this chapter, or health care benefits under another health care program administered by the department or a program identified in subdivision (b), or ~~both~~ all of them.

~~(d)~~

(e) Where applicable, all laws, regulations, restrictions, conditions, and terms of participation regarding the possession, billing, and use of Medi-Cal cards shall also apply to a benefits identification card.

~~(e)~~

(f) For the purposes of this section, "benefits" includes medically necessary services, goods, supplies, or merchandise.

Section 14105.18 of the Welfare and Institutions Code is amended to read:

14105.18. (a) Notwithstanding any other provision of law, provider rates of payment for services rendered in all of the following programs shall be identical to the rates of payment for the same service performed by the same provider type pursuant to the Medi-Cal program.

(1) The California Children's Services Program established pursuant to Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code.

(2) The Genetically Handicapped Person's Program established pursuant to Article 1 (commencing with Section 125125) of Chapter 2 of Part 5 of Division 106 of the Health and Safety Code.

(3) The Breast and Cervical Cancer Early Detection Program established pursuant to Article 1.5 (commencing with Section 104150) of Chapter 2 of Part 1 of Division 103 of the Health and Safety Code and the breast cancer programs specified in Section 30461.6 of the Revenue and Taxation Code.

(4) The State-Only Family Planning Program established pursuant to Division 24 (commencing with Section 24000).

(5) The Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program established pursuant to subdivision (aa) of Section 14132.

(6) The Healthy Families Program established pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code if the health care services are provided by a Medi-Cal provider.

(7) The Access for Infants and Mothers Program established pursuant to Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code if the health care services are provided by a Medi-Cal provider.

(b) The director may identify in regulations other programs not listed in subdivision (a) in which providers shall be paid rates of payment that are identical to the rates of payments in the Medi-Cal program pursuant to subdivision (a).

(c) Notwithstanding subdivision (a), services provided under any of the programs described in subdivisions (a) and (b) may be reimbursed at rates greater than the Medi-Cal rate that would otherwise be applicable if those rates are adopted by the director in regulations.

(d) This section shall become operative on July 1, 2011.